

AMENDED IN SENATE JUNE 1, 2015
AMENDED IN SENATE APRIL 21, 2015
AMENDED IN SENATE MARCH 26, 2015

SENATE BILL

No. 137

Introduced by Senator Hernandez

January 26, 2015

An act to add Section 1367.27 to the Health and Safety Code, and to add Section 10133.15 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 137, as amended, Hernandez. Health care coverage: provider directories.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. A willful violation of the act is a crime. Existing law requires a health care service plan to provide a list of contracting providers within a requesting enrollee's or prospective enrollee's general geographic area.

Existing law also provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires insurers subject to regulation by the commissioner to provide group policyholders with a current roster of institutional and professional providers under contract to provide services at alternative rates.

This bill would require health care service plans and insurers subject to regulation by the commissioner for services at alternative rates to make a provider directory available on its Internet Web site and to update the directory weekly. The bill would require the Department of

Managed Health Care and the Department of Insurance to develop provider directory standards. By placing additional requirements on health care service plans, the violation of which is a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1367.27 is added to the Health and Safety
2 Code, to read:
3 1367.27. (a) (1) A health care service plan shall make
4 available a provider directory or directories that shall provide
5 information on contracting providers, including those that accept
6 new patients, pursuant to the requirements of this section and
7 Section 1367.26. A provider directory shall not include information
8 on a provider that does not have a current contract with the plan.
9 (2) A plan shall provide the directory or directories for the
10 specific network offered for each product using a consistent method
11 of network and product naming, numbering, or other classification
12 method that ensures the public, enrollees, potential enrollees, the
13 department, and other state or federal agencies can easily identify
14 which providers participate in which networks for which products.
15 A health plan shall use the same consistent classification method
16 in provider contracts and communications to ensure that providers
17 can identify the products and networks that they are legally
18 contracted to provide services in. The classification shall be
19 consistent across plans in order to permit the department and other
20 state or federal agencies to construct multiplan directories.
21 (3) The provider directory or directories shall be available on
22 the plan's Internet Web site to the public and potential enrollees
23 without any requirement that a member of the public or potential
24 enrollee indicate intent to obtain coverage from the plan. The
25 directory or directories shall be available to the public without
26 requiring that an individual seeking the directory information

1 demonstrate coverage with the plan, provide a policy number,
2 provide any other identifying information, or create or access an
3 account.

4 (b) (1) The provider directory or directories shall be accessible
5 on the plan's public Internet Web site through a clearly identifiable
6 link or tab and in a manner that is accessible and searchable by
7 the public, potential enrollees, enrollees, and providers. The plan's
8 public Internet Web site shall allow for provider searches by name,
9 practice address, National Provider ~~Identification~~ *Identifier* number,
10 California license, facility or identification number, product, tier,
11 provider language, medical group, or independent practice
12 association, hospital, or clinic, as appropriate. If another technology
13 emerges that takes the place of Internet Web sites, the department
14 shall direct the plan to make the information required under this
15 section available on the subsequent technology in a timeframe that
16 allows for implementation of the technology, not to exceed six
17 months. The plan shall also make a paper copy of the directory or
18 directories available upon request.

19 (2) The plan shall update the provider directory or directories,
20 at least weekly, pursuant to paragraph (1) with any change to
21 contracting providers, including all of the following:

22 (A) Whether a contracting provider is no longer accepting new
23 patients, or that the provider moved or relocated from the
24 contracted service area of the plan, or has retired or has otherwise
25 ceased to practice.

26 (B) Whether the contracting provider group, if any, has
27 identified that the provider is no longer associated with the group
28 or is no longer accepting new patients.

29 (C) Whether the plan identified a change based on an enrollee
30 complaint that a provider was not accepting new patients or was
31 otherwise not available.

32 (D) Any other relevant information that has come to the attention
33 of the plan affecting the content of the provider directory.

34 (3) The provider directory or directories shall include both an
35 email address and a telephone number for members of the public
36 and providers to notify the plan if the provider directory
37 information appears to be inaccurate.

38 (4) By September 15, 2016, or no later than six months after
39 the date that provider directory standards are developed under

1 subdivision (d), a plan shall use the developed standards pursuant
2 to subdivision (d) for each product offered by the plan.

3 (c) A full service health care service plan shall include all of
4 the following information in the provider directory or directories:

5 (1) The provider's name, practice location or locations, and
6 contact information.

7 (2) Type of practitioner.

8 (3) National Provider-~~Identification~~ *Identifier* number.

9 (4) California license number and type of license.

10 (5) The area of specialty, including board certification, if any.

11 (6) (A) For physicians, the medical group, if any.

12 (B) Nurse practitioners, physician assistants, psychologists,
13 acupuncturists, optometrists, podiatrists, chiropractors, licensed
14 clinical social workers, marriage and family therapists, professional
15 clinical counselors, and nurse midwives to the extent their services
16 may be accessed and are covered through the contract with the
17 plan.

18 (C) For federally qualified health centers or primary care clinics,
19 the name of the federally qualified health center or clinic.

20 (D) For any provider described in subparagraph (A) or (B) who
21 is employed by a federally qualified health center or primary care
22 clinic, and to the extent their services may be accessed and are
23 covered through the contract with the plan, the name of the
24 provider, and the name of the federally qualified health center or
25 clinic.

26 (7) Hospital admitting privileges, if any, for physicians and
27 other health professionals contracted with the plan whose scope
28 of services for the plan include admitting patients and who have
29 admitting privileges at a hospital.

30 (8) Non-English language, if any, spoken by a health
31 professional as well as non-English language, if any, spoken by
32 the provider's staff.

33 (9) Whether a provider is accepting new patients with the
34 product selected by the enrollee or potential enrollee.

35 (10) Network tier to which the provider is assigned, if applicable.
36 "Tiered provider network" means a network of participating
37 providers that has been divided into subgroupings differentiated
38 by the health plan according to enrollee cost-sharing levels or
39 quality scores. Nothing in this section shall be construed to require

1 the use of network tiers other than contract and noncontracting
2 tiers.

3 (11) A disclosure that enrollees are entitled to full and equal
4 access to covered services, including enrollees with disabilities as
5 required under the *federal Americans with Disabilities Act of 1990*
6 and Section 504 of the Rehabilitation Act of 1973.

7 (12) All other information necessary to conduct a search
8 pursuant to subdivision (b).

9 (d) A specialized health care service plan shall include all of
10 the following information for each of the provider directories used
11 by the plan for its networks:

12 (1) The provider's name, practice location or locations, and
13 contact information.

14 (2) Type of practitioner.

15 (3) National Provider Identification Identifier number.

16 (4) California license number and type of license.

17 (5) The area of specialty, including board certification, if any.

18 (6) If participating in a group practice, the name of the group
19 practice.

20 (7) The names of any allied health care professionals to the
21 extent their services are covered through the contract with the plan.

22 (8) Non-English language, if any, spoken by a health provider
23 as well as non-English language, if any, spoken by the provider's
24 staff.

25 (9) Whether a provider is accepting new patients enrolled in the
26 product that the directory applies to.

27 (10) A disclosure that enrollees are entitled to full and equal
28 access to covered services, including enrollees with disabilities as
29 required under the *federal Americans with Disabilities Act of 1990*
30 and Section 504 of the Rehabilitation Act of 1973.

31 (e) (1) By March 15, 2016, the department and the Department
32 of Insurance shall develop *uniform* provider directory standards
33 for purposes of ~~paragraph (3) of subdivision (b)~~. *subdivision (b)*
34 *which would allow directories to be aggregated and searchable*
35 *to determine the plan a physician or other provider is available*
36 *through*.

37 ~~(2) The standards shall be sufficient to permit a single uniform~~
38 ~~electronic directory that would allow a member of the public to~~
39 ~~determine whether a physician or other provider is available to an~~
40 ~~enrollee of the California Health Benefit Exchange, a beneficiary~~

1 of the Medi-Cal program enrolled in a Medi-Cal managed care
2 plan, as well as to an enrollee with group coverage.

3 (3)

4 (2) The department and the Department of Insurance shall seek
5 input from interested parties, including holding at least one public
6 meeting. In developing the directory standards, the department
7 shall take into consideration any requirements for provider
8 directories established by the federal Centers for Medicare and
9 Medicaid Services.

10 (f) (1) The plan shall provide the directory or directories to the
11 department in a format and manner to be specified by the
12 department.

13 (2) The plan shall demonstrate no less than quarterly to the
14 department that the information provided in the provider directory
15 or directories is consistent with the information required under
16 Sections 1367.03 and 1367.035, and other provisions of this
17 chapter. The plan shall ~~assure~~ *ensure* that other information
18 reported to the department is consistent with the information
19 provided to enrollees, potential enrollees, and the department
20 pursuant to this section.

21 (3) The plan shall demonstrate to the department that enrollees
22 or potential enrollees seeking a provider that is contracted with
23 the network for a particular product can identify these providers
24 and that the provider is accepting new patients. The plan shall
25 ensure that the accuracy of the provider directory meets or exceeds
26 97 percent.

27 (4) The plan shall contact any provider which is listed in the
28 provider directory and which has not submitted a claim within the
29 past three months for primary care providers, or six months for
30 specialty care providers, to determine whether the provider is
31 accepting patients or referrals from the plan, if claims are paid by
32 the plan. If claims are not paid by the plan, the plan shall contact
33 any provider that is listed in the provider directory who has not
34 submitted encounter data within the past three months for primary
35 care providers, or six months without encounter data for a specialty
36 care provider. If the provider does not respond within 30 days, the
37 plan shall remove the provider from the provider directory. This
38 requirement does not apply to claims or encounter data from new
39 primary care providers in the first three months, or new specialty
40 care providers in the first six months, of the contract.

1 (g) The plan shall make available an electronic copy of, or upon
2 request, one physical copy of the provider directory or directories
3 to the following:

4 (1) To the State Department of Health Care Services for
5 Medi-Cal managed care plans.

6 (2) To the California Health Benefit Exchange for the networks
7 of the products offered through the California Health Benefit
8 Exchange, as required by contract.

9 (3) On request by the Public Employees' Retirement System,
10 to the Public Employees' Retirement System.

11 (4) The department and the Department of Insurance.

12 (5) On request by a group purchaser, provider directory or
13 directories for the products available in the market segment of the
14 group.

15 (h) If a contracting provider, or the representative of a
16 contracting provider, informs an enrollee or potential enrollee that
17 the provider is not accepting new patients, the contract between
18 the plan and the provider shall require the provider to inform the
19 plan that the provider is not accepting new patients and direct the
20 enrollee or potential enrollee to the plan for additional assistance
21 in finding a provider and also to the department to inform it of the
22 possible inaccuracy in the provider directory. If an enrollee or
23 potential enrollee informs a plan of a possible inaccuracy in the
24 provider directory or directories, the plan shall undertake
25 immediate corrective action to ensure the accuracy of the directory
26 or directories.

27 (i) This section does not prohibit a plan from requiring its
28 contracting providers, contracting provider groups, or contracting
29 specialized health care plans to satisfy the requirements of this
30 section. If a plan delegates the responsibility of complying with
31 this section to its contracting providers, contracting provider
32 groups, or contracting specialized health care plans, the plan shall
33 ensure that the requirements of this section are met.

34 (j) Every health care service plan shall ensure processes are in
35 place to allow providers to promptly verify or submit changes to
36 demographic information and participation status. Those processes
37 shall, at a minimum, include an online interface for providers to
38 submit verification or changes electronically and shall allow
39 providers to receive an acknowledgment of receipt from the health
40 care service plan. Providers shall verify or submit changes to

1 demographic information and participation status using this process
2 according to the terms of their contract with the contracted health
3 plan.

4 (k) Every health care service plan shall allow enrollees to request
5 the information required by this section through their toll-free
6 telephone number, electronically, or in writing. On request of an
7 enrollee or potential enrollee, the plan shall provide the information
8 required under subdivisions (a), (b), (c), and (g) in written form.
9 The information provided in written form may be limited to the
10 geographic region in which the enrollee or potential enrollee resides
11 or intends to reside.

12 SEC. 2. Section 10133.15 is added to the Insurance Code, to
13 read:

14 10133.15. (a) (1) A health insurer that contracts with providers
15 for alternative rates of payment pursuant to Section 10133 shall
16 make available a provider directory or directories that shall provide
17 information on contracting providers, including those that accept
18 new patients pursuant to the requirements of this section and
19 Section 10133.1. A provider directory shall not include information
20 on a provider that does not have a current contract with the insurer.

21 (2) An insurer shall provide the directory or directories for the
22 specific network offered for each product using a consistent method
23 of network and product naming, numbering, or other classification
24 method that ensures the public, insureds, potential insureds, the
25 department, and other state or federal agencies can easily identify
26 which providers participate in which networks for which products.
27 An insurer shall use the same consistent classification method in
28 provider contracts and communications to ensure that providers
29 can identify the products and networks that they are legally
30 contracted to provide services in. The classification shall be
31 consistent across products in order to permit the department and
32 other state or federal agencies to construct multiplan directories.

33 (3) The provider directory or directories shall be available on
34 the insurer's Internet Web site to the public and potential insureds
35 without any requirement that a member of the public or potential
36 insureds indicate intent to obtain coverage from the insurer. The
37 directory or directories shall be available to the public without
38 requiring that an individual seeking the directory information
39 demonstrate coverage with *the* insurer, provide a policy number,

1 provide any other identifying information, or create or access an
2 account.

3 (b) (1) The provider directory or directories shall be accessible
4 on the insurer's public Internet Web site through a clearly
5 identifiable link or tab and in a manner that is accessible and
6 searchable by the public, potential insureds, insureds, and
7 providers. The insurer's public Internet Web site shall allow for
8 provider searches by name, practice address, National Provider
9 ~~Index~~ *Identifier* number, California license number, facility or
10 identification number, product, tier, provider language, medical
11 group, or independent practice association, hospital, or clinic, as
12 appropriate. If another technology emerges that takes the place of
13 Internet Web sites, the department shall direct the insurer to make
14 the information required under this section available on the
15 subsequent technology in a timeframe that allows for
16 implementation of the technology, not to exceed six months. The
17 insurer shall also make a paper copy of the directory or directories
18 available upon request.

19 (2) The insurer shall update the provider directory *or* directories,
20 at least weekly, posted pursuant to paragraph (1) with any change
21 to contracting providers, including all of the following:

22 (A) Whether a contracting provider has notified the insurer that
23 the provider no longer intends to participate as a contracting
24 provider, is no longer accepting new patients, that the provider
25 moved or relocated from the contracted service area of the product,
26 or has retired or otherwise ceased to practice.

27 (B) Whether the contracting provider group, if any, has
28 identified that the provider is no longer associated with the group
29 or is no longer accepting new patients.

30 (C) Whether the insurer identified a change based on an insured
31 complaint that a provider was not accepting new patients or was
32 otherwise not available.

33 (D) Any other relevant information that has come to the attention
34 of the product affecting the content of the provider directory.

35 (3) The provider directory or directories shall include both an
36 email address and a telephone number for members of the public
37 and providers to notify the insurer if the provider directory
38 information appears to be inaccurate.

39 (4) By September 15, 2016, or no later than six months after
40 the date that provider directory standards are developed under

subdivision (d), an insurer shall use the developed standards pursuant to subdivision (d) for each product offered by the insurer.

(c) The insurer shall include all of the following information in the provider directory or directories:

(1) The provider's name, practice location or locations, and contact information.

(2) Type of practitioner.

(3) National Provider-~~Identification~~ *Identifier* number.

(4) California license number and type of license.

(5) The area of specialty, including board certification, if any.

(6) (A) For physicians, the medical group, if any.

(B) Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, and nurse midwives to the extent their services may be accessed and are covered through the contract with the insurer.

(C) For federally qualified health centers or primary care clinics, the name of the federally qualified health center or clinic.

(D) For any provider described in subparagraph (A) or (B) who is employed by a federally qualified health center or primary care clinic, and to the extent their services may be accessed and are covered through the contract with the insurer, the name of the provider, and the name of the federally qualified health center or clinic.

(7) Hospital admitting privileges, if any, for physicians and other health professionals contracted with the insurer whose scope of services for the product include admitting patients and who have admitting privileges at a hospital.

(8) Non-English language, if any, spoken by a health professional as well as non-English language, if any, spoken by the provider's staff.

(9) Whether a provider is accepting new patients with the product selected by the insured or potential insured.

(10) Network tier that the provider is assigned to, if applicable. "Tiered provider network" means a network of participating providers that has been divided into subgroupings differentiated by the insurer according to insured cost-sharing levels or quality scores. Nothing in this section shall be construed to require the

1 use of network tiers other than contracting and noncontracting
2 tiers.

3 (11) A disclosure that insureds are entitled to full and equal
4 access to covered services, including insureds with disabilities as
5 required under the *federal Americans with Disabilities Act of 1990*
6 and Section 504 of the Rehabilitation ~~Act~~. *Act of 1973*.

7 (12) All other information necessary to conduct a search
8 pursuant to subdivision (b).

9 (d) A specialized insurer shall include all of the following
10 information for each of the provider directories used by the insurer
11 for its networks:

12 (1) The provider's name, practice location or locations, and
13 contact information.

14 (2) Type of practitioner.

15 (3) National Provider-~~Identification~~ *Identifier* number.

16 (4) California license number and type of license.

17 (5) The area of specialty, including board certification, if any.

18 (6) If participating in a group practice, the name of the group
19 practice.

20 (7) The names of any allied health care professionals to the
21 extent their services are covered through the contract with the
22 insurer.

23 (8) Non-English language, if any, spoken by a health
24 professional as well as non-English language, if any, spoken by
25 the provider's staff.

26 (9) Whether a provider is accepting new patients enrolled in the
27 product that the directory applies to.

28 (10) A disclosure that insureds are entitled to full and equal
29 access to covered services, including insureds with disabilities as
30 required under the *federal Americans with Disabilities Act of 1990*
31 and Section 504 of the Rehabilitation ~~Act~~. *Act of 1973*.

32 (e) (1) By March 15, 2016, the Department of Managed Health
33 Care and the department shall develop a *uniform* provider directory
34 standards for purposes of ~~paragraph (3) of subdivision (b).~~
35 *subdivision (b) which would allow directories to be aggregated*
36 *and searchable to determine the plan a physician or other provider*
37 *is available through.*

38 ~~(2) The standards shall be sufficient to permit a single uniform~~
39 ~~electronic directory that would allow a member of the public to~~
40 ~~determine whether a physician or other provider is available to an~~

1 ~~insured of the California Health Benefit Exchange, a beneficiary~~
2 ~~of the Medi-Cal program enrolled in a Medi-Cal managed care~~
3 ~~plan, as well as to an insured with group coverage.~~

4 (3)

5 (2) The department and the Department of Managed Health
6 Care shall seek input from interested parties, including holding at
7 least one public meeting. In developing the directory standards,
8 the department and the Department of Managed Health Care shall
9 take into consideration any requirements for provider directories
10 established by the federal Centers for Medicare and Medicaid
11 Services.

12 (f) (1) The insurer shall provide the directory or directories to
13 the department in a format and manner to be specified by the
14 department.

15 (2) The insurer shall demonstrate no less than quarterly to the
16 department that the information provided in the provider directory
17 or directories is consistent with the information required under
18 Section 10133.5 and other provisions of this part. The insurer shall
19 ~~assure~~ ensure that other information reported to the department is
20 consistent with the information provided to insureds, potential
21 insureds, and the department pursuant to this section.

22 (3) The insurer shall demonstrate to the department that insureds
23 or potential insureds seeking a provider that is contracted with the
24 network for a particular product can identify these providers and
25 that the provider is accepting new patients. The insurer shall ensure
26 that the accuracy of the provider directory meets or exceeds 97
27 percent.

28 (4) The insurer shall contact any provider which is listed in the
29 provider directory and which has not submitted a claim within the
30 past three months for primary care providers, or six months for
31 specialty care providers, to determine whether the provider is
32 accepting patients or referrals from the insurer, if claims are paid
33 by the insurer. If the provider does not respond within 30 days,
34 the insurer shall remove the provider from the provider directory.
35 This requirement does not apply to claims or claim data from new
36 primary care providers in the first three months, or new specialty
37 care providers in the first six months, of the contract.

38 (g) The insurer shall make available an electronic copy of, or
39 upon request, one physical copy of the provider directory or
40 directories to the following:

1 (1) To the State Department of Health Care Services for
2 Medi-Cal managed care plans.

3 (2) To the California Health Benefit Exchange for the networks
4 of the products offered through the California Health Benefit
5 Exchange, as required by contract.

6 (3) On request by the Public Employees' Retirement System,
7 to the Public Employees' Retirement System.

8 (4) The department and the Department of Managed Health
9 Care.

10 (5) On request by a group purchaser, provider directory or
11 directories for the products available in the market segment of the
12 group.

13 (h) If a contracting provider, or the representative of a
14 contracting provider, informs an insured or potential insured that
15 the provider is not accepting new patients, the contract between
16 the insurer and the provider shall require the provider to inform
17 the insurer that the provider is not accepting new patients and direct
18 the insured or potential insured to the insurer for additional
19 assistance in finding a provider and also to the department to
20 inform it of the possible inaccuracy in the provider directory. If
21 an insured or potential insured informs an insurer of a possible
22 inaccuracy in the provider directory or directories, the insurer shall
23 undertake immediate corrective action to ensure the accuracy of
24 the directory or directories.

25 (i) This section does not prohibit an insurer from requiring its
26 contracting providers, contracting provider groups, or contracting
27 specialized health care plans to satisfy the requirements of this
28 section. If an insurer delegates the responsibility of complying
29 with this section to its contracting providers, contracting provider
30 groups, or contracting specialized health care plans, the insurer
31 shall ensure that the requirements of this section are met.

32 (j) Every insurer shall ensure processes are in place to allow
33 providers to promptly verify or submit changes to demographic
34 information and participation status. Those processes shall, at a
35 minimum, include an online interface for providers to submit
36 verification or changes electronically and shall allow providers to
37 receive an acknowledgment of receipt from the health insurer.
38 Providers shall verify or submit changes to demographic
39 information and participation status using this process according
40 to the terms of their contract with the insurer.

1 (k) Every health insurer shall allow insureds to request the
2 information required by this section through their toll-free
3 telephone number, electronically, or in writing. On request of an
4 insured or potential insured, the insurer shall provide the
5 information required under subdivisions (a), (b), (c), and (g) in
6 written form. The information provided in written form may be
7 limited to the geographic region in which the insured or potential
8 insured resides or intends to reside.

9 SEC. 3. No reimbursement is required by this act pursuant to
10 Section 6 of Article XIII B of the California Constitution because
11 the only costs that may be incurred by a local agency or school
12 district will be incurred because this act creates a new crime or
13 infraction, eliminates a crime or infraction, or changes the penalty
14 for a crime or infraction, within the meaning of Section 17556 of
15 the Government Code, or changes the definition of a crime within
16 the meaning of Section 6 of Article XIII B of the California
17 Constitution.